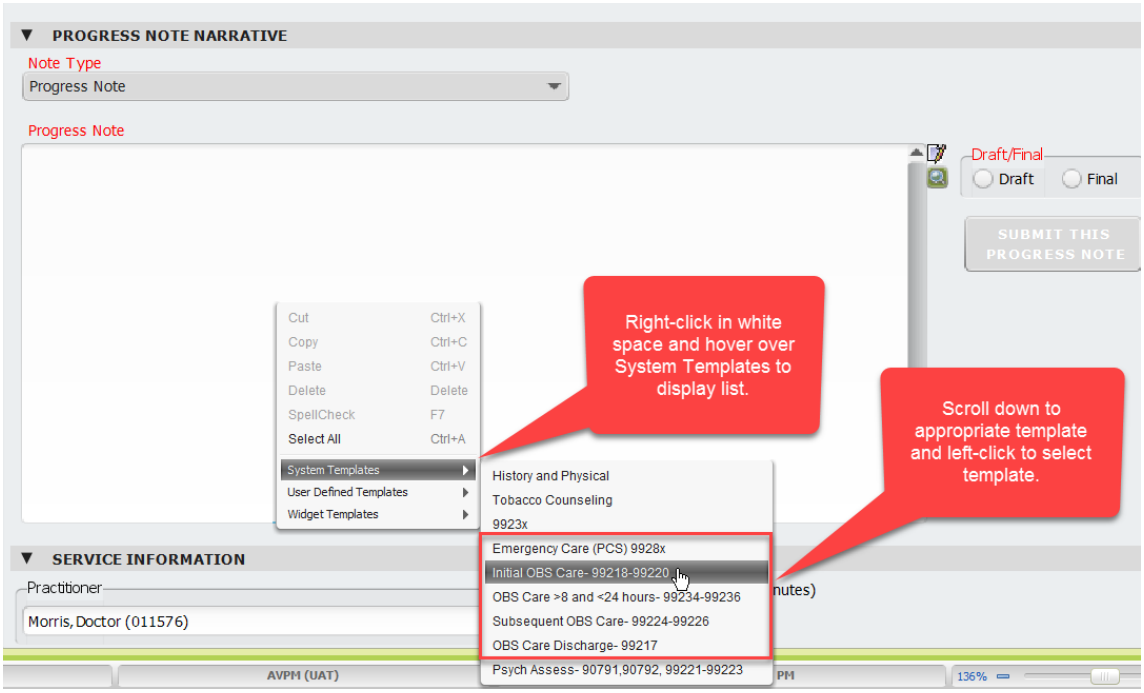
MILWAUKEE COUNTY BHD Behavioral Health Division

myAvatar™ Tips and Tricks

System Templates for Emergency and Observation Care- use the guidelines below for accessing system templates to document care in the Individual Progress Note and Crisis Progress Note.

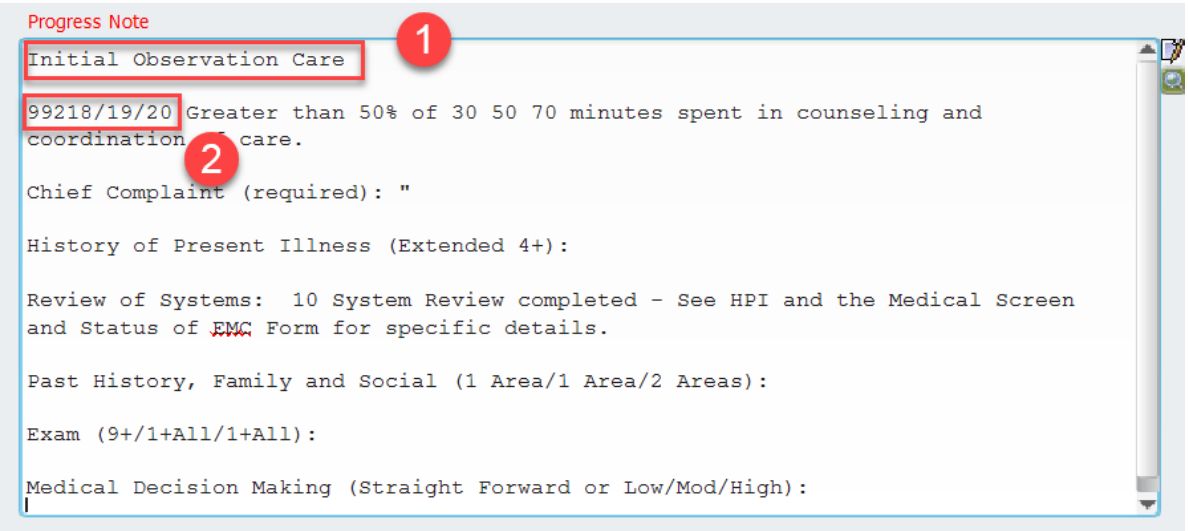
Beginning December 17, 2018, BHD is implementing new standards for documenting emergency and observation care in the Individual Progress Note and Crisis Progress Note. There are 5 new system templates (one for emergency care and 4 for observation care) to use within the narrative portion of the Individual Progress Note and Crisis Progress Note forms. To access the templates, right-click in the scrolling free-text field in either note and hover your mouse over **System Templates** to display a list of the new templates. To select the appropriate template, scroll down the list and left-click to select the appropriate template.



The template opens in the scrolling-text box field. Each template has:

1. Title of the template.
2. Range of billing codes (when applicable) for the template.

Sample System Template



Scroll through the entire template inserting information as needed (all required fields need to be completed for accurate billing documentation) and deleting information as appropriate. See the following pages for template examples and comprehensive 'how to use' instructions for each template.

Instructions for Use (99218-99220):

How to use:

The template lists the Evaluation and Management billing required headings and content of notes; for each of the three levels the number of elements or bullets needing documentation to meet that level of code. You will need to edit or modify some of the lines to the level of the code your billing. In each line with multiple options, the first option corresponds to the 99218 code requirements, the second the 99219 requirements and the third the 99220 requirements. Note there are NO optional elements or heading when using the codes for Initial Observation Care.

Billing Code Line:

99218/19/20 Greater than 50% of 30 50 70 minutes spent in counseling and coordination of care.

You have a strategic choice, you can bill, and code based upon the elements/bullets or you can bill based on time spent in counseling or coordination of care. Observation care allows you to count time spent at the bedside and on the patient's hospital floor or unit to be 50% of the time anchor for the code.

If you are going to bill for time spent in counseling or coordination of care the time anchors required are present as are the appropriate compliant language; e.g., you've met with the patient and greater than half of 50 minutes was spent in counseling the patient, your edited line would be: 99219 Greater than 50% of 50 minutes spent in counseling and coordination of care.

If you are going to bill based upon the bullets, edit the line down to just the base billing code. e.g., you've met with a patient for a high risk, high complexity decision making E&M visit, your edited line would be: 99220

Remember Counseling is NOT psychotherapy - if your Billing for conjoined E&M with Psychotherapy you must bill the E&M portion by the bullets and also document the psychotherapy portion - This will be covered in a subsequent update class.

> Counseling: Diagnostic Results, Impressions, Diagnostic Studies, Prognosis, Risks and Benefits of Treatment Options, Instructions for Management and/or Follow-Up, Importance of Compliance, Risk Factor Reduction, Patient and Family Education
>
> Coordination of Care: Establishing/Reviewing Patient's Chart, Writing Notes, Communication with Other Professionals, Communication with Patient's Family, Scheduling Treatments

CC Line:

Chief Complaint (required): "

> Place our cursor right of the ", type in the Chief Complaint."
>
> e.g., Chief Complaint (required): "I want to go home..."

HPI Line:

History of Present Illness (Extended 4+):

All three levels of Initial Observation Care require an Extended, 4+ History of Present Illness, meaning you need to assess and document 4 symptoms or aspects of the illness (PQRST dimensions of symptom).

Note, if you are billing by time for Counseling and Coordination of care describe the activities completed for counseling, etc AND any clinically, risk or medico-legally necessary other HPI data.

ROS Line:

Review of Systems: 10 System Review completed - See HPI and the Medical Screen and Status of EMC Form for specific details.

Per the 1995/1997 CMS E&M Documentation requirements there are 14 systems: Constitutional, HEENT (Eyes, Ears, Nose, Mouth and Throat), Cardiovascular, Respiratory, Gastrointestinal, Genitourinary, Musculoskeletal, Integumentary (skin and/or breast), Neurological, Psychiatric, Endocrine, Hematologic/Lymphatic and Allergic/Immunologic.

To meet the CPT requirements a 99281 requires no ROS, 99282-99283 requires 1 system reviewed and documented, a 99284 requires 2 systems, 99285 require 10 or more systems reviewed.

For PCS, the Review of Systems by MCBHD policy is documented in the *Medical Screen and Status of EMC* Form in Avatar EHR. The systems reviewed are Psychiatric, Integumentary (skin and/or breast), Musculoskeletal, Constitutional, HEENT, Neurological, Respiratory, Cardiovascular, Gastrointestinal, Genitourinary. Your entries on that form and in the HPI/Past History for psychiatry meet this requirement.

PHx FSHx Line:

Past History, Family and Social (1 Area/1 Area/2 Areas):

For the past history section, you need to review document one of the three areas (Past History, Family History or Social History) for 99218 and 99219 and for 99220 you need to pick two areas. Again, if you are billing by time for Counseling and Coordination of care you may delete/document what is most appropriate in a medico-legal sense/clinical quality sense.

Psychiatry Specialty Exam Line:

Exam (9+/1+All/1+All):

We use the CMS 1997 E&M Psychiatry Specialty Exam to document most billing encounters. Please keep in mind that the exam requirements for billing are starting point for documenting and in general for good clinical care and medico-legal requirements you will exceed these minimums. However, you likely will not be able to up-code on the bases of a more thorough exam alone. Also, please note that the CMS 1997 E&M Psychiatry Specialty Exam is not just a Mental Status Exam (MSE), there are three areas including Musculoskeletal, Constitutional and Psychiatric.

Again, the E&M Billing requirements are a minimum and adequate documentation of exam for risk mitigation is often more important. Moreover, also note again, if you are billing by time for Counseling and Coordination of care describe the activities completed for counseling, etc AND any clinically, risk or medico-legally necessary other HPI data.

For 99218 you need to assess and document nine or more elements and for both 99219 and 99220 you need one element from musculoskeletal and all elements in both the constitutional and psychiatric domains.

MDM Line:

Medical Decision Making (Straight Forward or Low/Mod/High):

Medical Decision Making (MDM) is more than just listing a diagnosis (which you are required to do); it is more than an assessment and plan. It is the integrative cognitive work of weighing the data and information, determining what additional data and work up are needed, weighing relative risk of types of evaluations and treatment and determining the collective complexity.

Per CMS the levels of E/M services recognize four types of medical decision making (straightforward, low complexity, moderate complexity and high complexity). Medical decision making refers to the complexity of establishing a diagnosis and/or selecting a management option as measured by:

- the number of possible diagnoses and/or the number of management options that must be considered;
- the amount and/or complexity of medical records, diagnostic tests, and/or other information that must be obtained, reviewed and analyzed; and
- the risk of significant complications, morbidity and/or mortality, as well as comorbidities, associated with the patient's presenting problem(s), the diagnostic procedure(s) and/or the possible management options.

The specifics of Medical Decision Making will be reviewed in detail at a future Billing and Coding Update.

- 99218 is for problems of low severity with low complexity MDM.
- 99219 is for problems of moderate severity with moderate complexity MDM.
- 99220 is for problems of high severity high complexity MDM.

In the case of billing by time in counseling and coordination of care, you still need to document your integrative cognitive work, differential diagnosis, prescribed work-up and treatment plan, etc, though you are not required to make the bullet/point based score weighing all the data; again this needs to be consistent with clinically appropriate and medico-legally needed.

OBS Templates – 99234-99236 Observation Care >8 and <24 hours.

Short-term Initial Observation Care Template.

99234/5/6 Greater than 50% of 40 50 55 minutes spent in counseling and coordination of care.

Chief Complaint (required): "

History of Present Illness (Extended 4+):

Review of Systems: 10 System Review completed - See HPI and the Medical Screen and Status of EMC Form for specific details.

Past History, Family and Social (1 Area/2 Areas/2 Areas):

Exam (9+/1+All/1+All):

Medical Decision Making (Straight Forward or Low/Mod/High):

Instructions for Use (99234-99236):

How to use:

These Observation codes are unique in that they are used if a patient is both admitted and discharged on the same calendar date AND that the following criteria must be met:

- The patient must be in observation for a minimum of 8 hours.
- The billing physician must be present and show active involvement by charting condition updates, orders, etc.
- Both the admission and discharge notes are written by the billing physician (or may be billed by 2 physicians within the same group practice).

Otherwise, the template and levels are quite like the Initial Observation Care Codes. I will review some of the high-level items and list major differences from the other initial codes.

Similar to the other templates, this one lists the Evaluation and Management billing required headings and content of notes; for each of the three levels the number of elements or bullets needing documentation to meet that level of code. You will need to edit or modify some of the lines to the level of the code your billing. In each line with multiple options, the first option corresponds to the 99234 code requirements, the second the 99235 requirements and the third the 99236 requirements. Note there are NO optional elements or heading when using the codes for Initial Observation Care.

Billing Code Line:

99234/5/6 Greater than 50% of 40 50 55 minutes spent in counseling and coordination of care.

As with most of the E&M Code, you have a strategic choice, you can bill, and code based upon the elements/bullets or you can bill based on time spent in counseling or coordination of care. Observation care allows you to count time spent at the bedside and on the patient's hospital floor or unit to be 50% of the time anchor for the code.

If you are going to bill for time spent in counseling or coordination of care the time anchors required are present as are the appropriate compliant language; e.g., you've met with the patient and greater than half of 50 minutes was spent in counseling the patient, your edited line would be: 99235 Greater than 50% of 50 minutes spent in counseling and coordination of care.

If you are going to bill based upon the bullets, edit the line down to just the base billing code. e.g., you've met with a patient for a high risk, high complexity decision making E&M visit, your edited line would be: 99236

Remember Counseling is NOT psychotherapy - if your Billing for conjoined E&M with Psychotherapy you must bill the E&M portion by the bullets and also document the psychotherapy portion - This will be covered in a subsequent update class.

> Counseling: Diagnostic Results, Impressions, Diagnostic Studies, Prognosis, Risks and Benefits of Treatment Options, Instructions for Management and/or Follow-Up, Importance of Compliance, Risk Factor Reduction, Patient and Family Education
>
> Coordination of Care: Establishing/Reviewing Patient's Chart, Writing Notes, Communication with Other Professionals, Communication with Patient's Family, Scheduling Treatments

CC Line:

Chief Complaint (required): "

> Place our cursor right of the ", type in the Chief Complaint."
>
> e.g., Chief Complaint (required): "I want to go home..."

HPI Line:

History of Present Illness (Extended 4+):

All three levels of Initial Observation Care require an Extended, 4+ History of Present Illness, meaning you need to assess and document 4 symptoms or aspects of the illness (PQRST dimensions of symptom).

Note, if you are billing by time for Counseling and Coordination of care describe the activities completed for counseling, etc AND any clinically, risk or medico-legally necessary other HPI data.

ROS Line:

Review of Systems: 10 System Review completed - See HPI and the Medical Screen and Status of EMC Form for specific details.

Per the 1995/1997 CMS E&M Documentation requirements there are 14 systems: Constitutional, HEENT (Eyes, Ears, Nose, Mouth and Throat), Cardiovascular, Respiratory, Gastrointestinal, Genitourinary, Musculoskeletal, Integumentary (skin and/or breast), Neurological, Psychiatric, Endocrine, Hematologic/Lymphatic and Allergic/Immunologic.

To meet the CPT requirements a 99281 requires no ROS, 99282-99283 requires 1 system reviewed and documented, a 99284 requires 2 systems, 99285 require 10 or more systems reviewed.

For PCS, the Review of Systems by MCBHD policy is documented in the *Medical Screen and Status of EMC* Form in Avatar EHR. The systems reviewed are Psychiatric, Integumentary (skin and/or breast), Musculoskeletal, Constitutional, HEENT, Neurological, Respiratory, Cardiovascular, Gastrointestinal, Genitourinary. Your entries on that form and in the HPI/Past History for psychiatry meet this requirement.

Note, if you are billing by time for Counseling and Coordination of care describe the activities completed for counseling, etc AND any clinically, risk or medico-legally necessary other HPI data.

PHx FSHx Line:

Past History, Family and Social (1 Area/2 Areas/2 Areas):

For the past history section, you need to review document one of the three areas (Past History, Family History or Social History) for 99234 and for 99235 and 99236 you need to pick two areas. Again, if you are billing by time for Counseling and Coordination of care you may delete/document what is most appropriate in a medico-legal sense/clinical quality sense.

Psychiatry Specialty Exam Line:

Exam (9+/1+All/1+All):

We use the CMS 1997 E&M Psychiatry Specialty Exam to document most billing encounters. Please keep in mind that the exam requirements for billing are starting point for documenting and in general for good clinical care and medico-legal requirements you will exceed these minimums. However, you likely will not be able to up-code on the bases of a more thorough exam alone. Also, please note that the CMS 1997 E&M Psychiatry Specialty Exam is not just a Mental Status Exam (MSE), there are three areas including Musculoskeletal, Constitutional and Psychiatric.

Again, the E&M Billing requirements are a minimum and adequate documentation of exam for risk mitigation is often more important. Moreover, also note again, if you are billing by time for Counseling and Coordination of care describe the activities completed for counseling, etc AND any clinically, risk or medico-legally necessary other HPI data.

For 99234 you need to assess and document nine or more elements and for both 99235 and 99236 you need one element from musculoskeletal and all elements in both the constitutional and psychiatric domains.

MDM Line:

Medical Decision Making (Straight Forward or Low/Mod/High):

Medical Decision Making (MDM) is more than just listing a diagnosis (which you are required to do); it is more than an assessment and plan. It is the integrative cognitive work of weighing the data and information, determining what additional data and work up are needed, weighing relative risk of types of evaluations and treatment and determining the collective complexity.

Per CMS the levels of E/M services recognize four types of medical decision making (straightforward, low complexity, moderate complexity and high complexity). Medical decision making refers to the complexity of establishing a diagnosis and/or selecting a management option as measured by:

- the number of possible diagnoses and/or the number of management options that must be considered;
- the amount and/or complexity of medical records, diagnostic tests, and/or other information that must be obtained, reviewed and analyzed; and
- the risk of significant complications, morbidity and/or mortality, as well as comorbidities, associated with the patient's presenting problem(s), the diagnostic procedure(s) and/or the possible management options.

The specifics of Medical Decision Making will be reviewed in detail at a future Billing and Coding Update.

- 99234 is for problems of low severity with low complexity MDM.
- 99235 is for problems of moderate severity with moderate complexity MDM.
- 99236 is for problems of high severity high complexity MDM.

In the case of billing by time in counseling and coordination of care, you still need to document your integrative cognitive work, differential diagnosis, prescribed work-up and treatment plan, etc, though you are not required to make the bullet/point based score weighing all the data; again this needs to be consistent with clinically appropriate and medico-legally needed.

OBS Templates - 99224-99226 Subsequent Observation Care

Subsequent Observation Care Template.

99224 5 6 Greater than 50% of 15 25 35 minutes spent in counseling and coordination of care.

Chief Complaint (required): "

History of Present Illness (Brief 1-3, Extended 4+):

Review of Systems (NA/1 Pertinent/2 or more Pertinent):

Past History, Family and Social (NA/NA/1 Area):

Exam (Prob Focus 1-5, Expand Problem Focus 6-8, Detailed 9+):

Medical Decision Making (Straight Forward or Low/Moderate/High):

Instructions for Use (99224-99226):

How to use:

The template lists the E&M Required Headings and notes for each of the three levels the number of elements or bullets needing documentation to meet that level of code. You will need to edit or modify some of the lines to the level of the code your billing. In each line with multiple options, the first option corresponds to the 99224 level code requirements, the second the 99225 level, etc...

Billing Code Line:

99224 5 6 Greater than 50% of 15 25 35 minutes spent in counseling and coordination of care.

As with most of the E&M Code, you have a strategic choice, you can bill, and code based upon the elements/bullets or you can bill based on time spent in counseling or coordination of care. Observation care allows you to count time spent at the bedside and on the patient's hospital floor or unit to be 50% of the time anchor for the code.

If you are going to bill for time spent in counseling or coordination of care the time anchors required are present as are the appropriate compliant language; e.g., you've met with the patient and greater than half of 25 minutes was spent in counseling the patient, your edited line would be: 99225 Greater than 50% of 50 minutes spent in counseling and coordination of care.

If you are going to bill based upon the bullets, edit the line down to just the base billing code. e.g., you've met with a patient for a high risk, high complexity decision making E&M visit, your edited line would be: 99226

Remember Counseling is NOT psychotherapy - if your Billing for conjoined E&M with Psychotherapy you must bill the E&M portion by the bullets and also document the psychotherapy portion - This will be covered in a subsequent update class.

> Counseling: Diagnostic Results, Impressions, Diagnostic Studies, Prognosis, Risks and Benefits of Treatment Options, Instructions for Management and/or Follow-Up, Importance of Compliance, Risk Factor Reduction, Patient and Family Education
>
> Coordination of Care: Establishing/Reviewing Patient's Chart, Writing Notes, Communication with Other Professionals, Communication with Patient's Family, Scheduling Treatments

CC Line:

Chief Complaint (required): "

Place our cursor right of the ", type in the Chief Complaint."

e.g**., Chief Complaint (required):** "I want to go home..."

HPI Line:

History of Present Illness (Brief 1-3, Extended 4+):

For a 99224 or 99225 Level you need 3 symptoms or aspects of the illness (PRRST dimensions of symptom). For the 99226 Level you need 4+

If you are billing by time for Counseling and Coordination of care describe the activities completed for counseling, etc AND any clinically, risk or medico-legally necessary other HPI data.

ROS Line:

Review of Systems (NA/1 Pertinent/2 or more Pertinent):

The Systems review need to be pertinent to the problem (including the differential diagnosis) or those impacted by the associated treatment. If you are billing 99224 level, or by time for Counseling and Coordination of care you may delete this line.

PHx FSHx Line:

Past History, Family and Social (NA/NA/1 Area):

The History, medical, family and/or social review need to be pertinent to the problem (including the differential diagnosis) or those impacted by the associated treatment. If you are billing 99224 or 99225 you do not need this documented and you may delete this line. For 99226 you need one history area.

Psychiatry Specialty Exam Line:

Exam (Prob Focus 1-5, Expand Problem Focus 6-8, Detailed 9+):

We use the CMS 1997 E&M Psychiatry Specialty Exam to document most billing encounters. Please keep in mind that the exam requirements for billing are starting point for documenting and in general for good clinical care and medico-legal requirements you will exceed these minimums. However, you likely will not be able to up-code on the bases of a more thorough exam alone. Also, please note that the CMS 1997 E&M Psychiatry Specialty Exam is not just a Mental Status Exam (MSE), there are three areas including Musculoskeletal, Constitutional and Psychiatric.

Again, the E&M Billing requirements are a minimum and adequate documentation of exam for risk mitigation is often more important.

For 99224 you need only one to five exam elements, 99225 needs six to eight elements and 99225 needs one element from musculoskeletal and all elements in both the constitutional and psychiatric domains.

MDM Line:

Medical Decision Making (Straight Forward or Low/Mod/High):

Medical Decision Making (MDM) is more than just listing a diagnosis (which you are required to do); it is more than an assessment and plan. It is the integrative cognitive work of weighing the data and information, determining what additional data and work up are needed, weighing relative risk of types of evaluations and treatment and determining the collective complexity.

Per CMS the levels of E/M services recognize four types of medical decision making (straightforward, low complexity, moderate complexity and high complexity). Medical decision making refers to the complexity of establishing a diagnosis and/or selecting a management option as measured by:

- the number of possible diagnoses and/or the number of management options that must be considered;
- the amount and/or complexity of medical records, diagnostic tests, and/or other information that must be obtained, reviewed and analyzed; and
- the risk of significant complications, morbidity and/or mortality, as well as comorbidities, associated with the patient's presenting problem(s), the diagnostic procedure(s) and/or the possible management options.

The specifics of Medical Decision Making will be reviewed in detail at a future Billing and Coding Update.

- 99224 is for where patients are stable, recovering or improving with low complexity MDM.
- 99225 is for where the patient is responding inadequately to therapy or has developed a minor complication with moderate complexity MDM.
- 99226 is for patients who are unstable, have developed a significant complication or a significant new problem with high complexity MDM.

In the case of billing by time in counseling and coordination of care, you still need to document your integrative cognitive work, differential diagnosis, prescribed work-up and treatment plan, etc, though you are not required to make the bullet/point based score weighing all the data; again, this needs to be consistent with clinically appropriate and medico-legally needed.

OBS Templates – 99217 Observation Care Discharge.

Observation Care Discharge Template.

99217

Reason for Observation Care:

Medical History:

Physical Examination Findings: See Report of Consultant for Details. / Refused.

Laboratory Tests:

Course of Observation Care:

Conditions of Patient on Discharge:

Risk Status (See SAFE-T for details): Short-term risk

Post Hospitalization Plan: See Crisis Discharge Summary for Details.

Discharge Medication List: See Crisis Discharge Summary for Details.

Legal Status:

Special Instructions (Diet, Activity):

Instructions for Use (99217):

How to use:

This code is for discharge from observation care management and is to be utilized to report all services provided to the patient during their observation stay. This includes the final examination of the patient, discussion of the hospital stay, instructions for continuing care, and preparation of all the associated records.

Title Line:

99217 – Observation Care Discharge

CPT Code line – informational only for clarity when other individuals review the care episode.

Why Hospitalized Line:

Reason for Observation Care:

Enter a short, synthetic statement explaining the reason for the stay. This is not intended to be a patient literal quote, but rather an expert assessment by the discharging physician; e.g., adjusted clozapine therapy in complex patient, prolonged diagnostic and risk assessment for patient with new onset psychosis, etc.

History Line:

Medical History:

List relevant medical, surgical and psychiatric comorbidities that are not part of the admitting or discharging diagnosis.

Physical Exam Findings Line:

Physical Examination Findings: See Report of Consultant for Details. / Refused.

Please edit the text via deleting the not relevant item, i.e., "See Report… ./" or "/ Refused." Also, please list any significant findings that are critical to highlight to the patient or subsequent care providers.

Test Results Line:

Laboratory Tests:

Please list test results including Point of Care (POC) tests done at BHD, EKGs and other studies like plain film x-rays. If there were none, enter "NA" or "None."

Hospital Course Line:

Course of Observation Care:

Please enter a short narrative discussion of the course of treatment while in observation. Treatment started, response, emergent difficulties and seclusion and restraint episodes are appropriate events to include.

Functional Status or Exam at Discharge Line:

Conditions of Patient on Discharge:

This is to be a narrative description on the patient at discharge from Observation Care. Either a functional assessment or a formal psychiatry specialty exam (MSE) is acceptable. For example: "Ambulatory, engaged in treatment and attending programing; consistently able to maintain personal safety despite minor psychotic symptoms."

Risk Assessment Line:

Risk Status (See SAFE-T for details): Short-term risk

Enter a synthetic or summary risk assessment that at a minimum lists short-term risk, such as "Short-term risk moderate for suicide and low for violence." Your entry should capture the most important points, while not a replacement for the SAFE-T (as the template points you to the form for details, this is the best place for capturing critical items for future providers in the patients transition of level of care.

Discharge Plan Line:

Post Hospitalization Plan: See Crisis Discharge Instructions for Details.

Do not edit; please use the Crisis Discharge Instructions to capture this information – either the pilot paper form or the anticipated Avatar Form/Report.

Discharge Medication List:

Discharge Medication List: Medication Reconciliation complete and discussed with patient. Please see Crisis Discharge Summary for Details.

Do not edit; ensure that you reconcile home medications, new medications and discharge medications with the patient including ensuring that Prior Authorizations if needed are completed. Please use the Crisis Discharge Instructions to capture the final prescription lists information – either the pilot paper form or the anticipated Avatar Form/Report.

Civil Commitment and Guardianship Status Line:

Legal Status:

List the patient's legal status such as: Voluntary, Guardianship, Settlement Agreement – Expires 1/15/2019, Civil Commitment – On Conditional Release, etc.

Additional/Special Instructions Line:

Special Instructions (Diet, Activity):

List any additional relevant items that need to be entered in the summary and passed on to subsequent providers both internal to BHD and externally. For example: ADA Qualitative Diet, Wheelchair bound but self-transfers, Needs interpretive Services – French, etc.

Template for Emergency Care (PCS) 99281-99285 called 9928x:

Emergency Care 9928x (Only by the elements/bullets)

Chief Complaint (required): "

History of Present Illness (Brief 1-3, Extended 4+):

Review of Systems: 10 System Review completed - See HPI and the Medical Screen and Status of EMC Form for specific details.

Past History, Family and Social (NA/NA/NA/1 Area/2 Areas):

Exam (1-5/1-5/6-8/9+/1+All):

Medical Decision Making (Straight Forward/Low/Mod/Mod/High):

Instructions for Use:

How to use:

The template lists the Evaluation and Management (E&M) Required Headings and notes for each of the five levels with the number of elements or bullets needing documentation to meet that level of code. You can delete out lines that have a NA for the level of E&M billing you need. In all but the History of Present Illness line, the first option corresponds to the level 1 (99281) code requirements, the second the level 2 (99282), etc...

Billing Code Line:

Emergency Care 9928x (Only by the elements/bullets)

Title only – no need to change or edit. Please note that all of the Emergency Care codes are by the elements or bullets and time-based coding is not allowed.

CC Line:

Chief Complaint (required): "

> Place our cursor right of the ", type in the Chief Complaint."
>
> **e.g., Chief Complaint (required): "I want to go home..."**

HPI Line:

History of Present Illness (Brief 1-3, Extended 4+):

For a Level 99281-99283 you need a brief history with 3 symptoms or aspects of the illness (PQRST dimensions of symptom) as part of the HPI elicited and documented.

For Level 99284-99285 you need an extended history with 4+.

ROS Line:

Review of Systems: 10 System Review completed - See HPI and the Medical Screen and Status of EMC Form for specific details.

Per the 1995/1997 CMS E&M Documentation requirements there are 14 systems: Constitutional, HEENT (Eyes, Ears, Nose, Mouth and Throat), Cardiovascular, Respiratory, Gastrointestinal, Genitourinary, Musculoskeletal, Integumentary (skin and/or breast), Neurological, Psychiatric, Endocrine, Hematologic/Lymphatic and Allergic/Immunologic.

To meet the CPT requirements a 99281 requires no ROS, 99282-99283 requires 1 system reviewed and documented, a 99284 requires 2 systems, 99285 require 10 or more systems reviewed.

For PCS, the Review of Systems by MCBHD policy is documented in the *Medical Screen and Status of EMC* Form in Avatar EHR. The systems reviewed are Psychiatric, Integumentary (skin and/or breast), Musculoskeletal, Constitutional, HEENT, Neurological, Respiratory, Cardiovascular, Gastrointestinal, Genitourinary. Your entries on that form and in the HPI/Past History for psychiatry meet this requirement.

PHx FSHx Line:

Past History, Family and Social (NA/NA/NA/1 Area/2 Areas):

The History, medical, family and/or social review need to be pertinent to the problem (including the differential diagnosis) or those impacted by the associated treatment. If you are billing 99281-99283 do not need this documented and you may delete this line. For 99284 you need one history area and for 99285 you need 2.

Psychiatry Specialty Exam Line:

Exam (1-5/1-5/6-8/9+/1+All):

We use the CMS 1997 E&M Psychiatry Specialty Exam to document most billing encounters. Please keep in mind that the exam requirements for billing are starting point for documenting and in general for good clinical care and medico-legal requirements you will exceed these minimums. However, you likely will not be able to up-code on the bases of a more thorough exam alone. Also, please note that the CMS 1997 E&M Psychiatry Specialty Exam is not just a Mental Status Exam (MSE), there are three areas including Musculoskeletal, Constitutional and Psychiatric.

Again, the E&M Billing requirements are a minimum and adequate documentation of exam for risk mitigation is often more important.

For 99281-99282 you need only one to five exam element, 99283 needs six to eight elements, 99284 needs nine or more elements and 99285 needs one element from musculoskeletal and all elements in both the constitutional and psychiatric domains.

MDM Line:

Medical Decision Making (Straight Forward/Low/Mod/Mod/High)

Medical Decision Making is more than just a diagnosis; it is more than an assessment and plan. It is the integrative cognitive work of weighing the data and information, determining what additional data and work up are needed, weighing relative risk of types of evaluations and treatment and determining the collective complexity.

Per CMS the levels of E/M services recognize four types of medical decision making (straightforward, low complexity, moderate complexity and high complexity). Medical decision making refers to the complexity of establishing a diagnosis and/or selecting a management option as measured by:

- the number of possible diagnoses and/or the number of management options that must be considered;
- the amount and/or complexity of medical records, diagnostic tests, and/or other information that must be obtained, reviewed and analyzed; and
- the risk of significant complications, morbidity and/or mortality, as well as comorbidities, associated with the patient's presenting problem(s), the diagnostic procedure(s) and/or the possible management options.

The specifics of Medical Decision Making will be reviewed in detail at a future Billing and Coding Update.

- 99281 requires a Self-Limited or Minor Problem and Straightforward Medical Decision.
- 99282 requires a Low or Moderate Severity Problem and Low Complexity Medical Decision.
- 99283 requires a Moderate Severity Problem and Moderate Complexity Medical Decision.
- 99284 requires a High Severity Problem and Moderate Complexity Medical Decision.
- 99285 requires a High Severity Problem and High Complexity Medical Decision.